



We gladly accept deliveries Monday-Saturday, excluding holidays  
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**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Gender**  Male  Female

**Clinical (Check All That Apply)**

<b>Eye</b> <input type="checkbox"/> Retinitis Pigmentosa <input type="checkbox"/> Optic Atrophy <input type="checkbox"/> Other	<b>Hearing</b> <input type="checkbox"/> Sensorineural <input type="checkbox"/> Stickler <input type="checkbox"/> Usher	<b>Neuronal Migration</b> <input type="checkbox"/> Meckel <input type="checkbox"/> Joubert <input type="checkbox"/> Other	<input type="checkbox"/> Stroke
<b>Cognitive/Neurobehavioral</b> <input type="checkbox"/> Intellectual Disability (ID) <input type="checkbox"/> Syndromic ID <input type="checkbox"/> Nonsyndromic ID <input type="checkbox"/> Autism <input type="checkbox"/> Dementia			
<b>Movement Disorders</b> <input type="checkbox"/> Ataxia <input type="checkbox"/> Episodic Ataxia <input type="checkbox"/> Dystonia <input type="checkbox"/> Chorea/Athetosis <input type="checkbox"/> Parkinson Disease <input type="checkbox"/> L-Dopa Response			
<b>Epilepsy</b> <input type="checkbox"/> Myoclonic <input type="checkbox"/> Other <input type="checkbox"/> Absence <input type="checkbox"/> Tonic Clonic <input type="checkbox"/> Epileptic Encephalopathy	<b>Spasticity</b> <input type="checkbox"/> Spastic Paraplegia <input type="checkbox"/> Other <input type="checkbox"/> Spastic Quadriplegia	<b>Connective Tissue &amp; Bone</b> <input type="checkbox"/> Ehlers Danlos <input type="checkbox"/> Marfan <input type="checkbox"/> Aneurysms <input type="checkbox"/> Other	
<b>Neuromuscular</b> <input type="checkbox"/> Distal <input type="checkbox"/> Proximal <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Contractures <input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> Arthrogryposis <input type="checkbox"/> Rhabdomyolysis <input type="checkbox"/> Periodic Paralysis <input type="checkbox"/> Statin Use <input type="checkbox"/> Myasthenia		<b>Nerve/Anterior Horn Cell</b> <input type="checkbox"/> Neurofibromas <input type="checkbox"/> Charcot-Marie-Tooth <input type="checkbox"/> Sensory <input type="checkbox"/> Autonomic <input type="checkbox"/> Pain <input type="checkbox"/> Motor <input type="checkbox"/> Nerve Conduction <input type="checkbox"/> Other	
<b>Cardiomyopathy</b> <input type="checkbox"/> Dilated <input type="checkbox"/> Hypertrophic <input type="checkbox"/> Noncompaction	<b>Arrhythmias</b> <input type="checkbox"/> Ventricular Tachycardia <input type="checkbox"/> Brugada <input type="checkbox"/> Long or Short QT <input type="checkbox"/> Conduction Defect	<b>Congenital Heart Defects</b> <input type="checkbox"/> Heterotaxy <input type="checkbox"/> Other	<b>Endocrine</b> <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Other <input type="checkbox"/> Diabetes Mellitus

**Imaging (Check All That Apply)**

**Brain MRI**  
 Leigh Disease  Basal Ganglia Calcification  Stroke  Cerebellar Atrophy  Abnormal Myelin (describe) \_\_\_\_\_

**EEG (Describe Findings)**  
\_\_\_\_\_

**EMG/NVC (Describe Findings)**  
\_\_\_\_\_

**Laboratory**

<b>Metabolic (Describe Findings)</b> _____	<b>Genetic (Describe Findings)</b> _____
<b>CPK</b> Maximum _____ Minimum _____	<input type="checkbox"/> Chromosomal Microarray <input type="checkbox"/> Deletion/Insertion Testing <input type="checkbox"/> Other (comment)

**Family History**

**Ethnicity (please check)**  
\_\_\_\_\_

South Asian  European (Non-Finnish)  Latino  Other (comment)  
 East Asian  European (Finnish)  African

Affected Maternal Lineage	Affected Paternal Lineage	Siblings
Relationship to Proband	Relationship to Proband	Number (specify gender)
Symptoms	Symptoms	Healthy/Affected

**Additional Comments**